



INTERNATIONAL SOCIETY OF
HYPERTENSION

A Member of the Scientific Advisory Board
of the **World Heart Federation**

Hypertension News

Opus 8, October 2005

Cheers and boos at ASCOT
(see pp 7-11)



TO: Members of the International Society of Hypertension

We should like to inform you that the ISH has a new Secretariat. All enquiries regarding your membership and other aspects of the Society should be addressed as follows:

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Any opinions expressed in the email are those of the individual and not necessarily of the Society. This email and any files transmitted with it are confidential and solely for the use of the intended recipient to whom they are addressed. If you are not the intended recipient or the person responsible for delivering to the intended recipient, be advised.

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As shown on page 1, ISH now has a new website. As soon as we get the updated membership list in order, we will add more information on the website *available for paying ISH members only*. The access code will be sent out later this year or early next year from our Secretariat. Those who have not paid the fees for the last two years or longer are at risk of being struck off the list (according to ISH By-Laws, Article III:7.0).

Finally, thanks for all your comments and encouraging remarks which we received before summer. It is fantastic that several hundred ISH members responded within a few days when we sent out a questionnaire attached to Opus 7. The overall assessment [mean (SD), 5=best, 1=worst] was a favourable 4.0 (0.7) and members found the newsletter easy to open, 4.3 (0.8) and of an appropriate size, 3.7 (1.0).

Please recruit new members!

Enjoy,

Lars H Lindholm
Editor of ISH News

REPORT FROM THE PRESIDENT
MH Alderman
New York, U.S.A.

The 2005 ISH Scientific Council met in conjunction with the European Society of Hypertension Scientific Session in Milan in mid-June. Attendance was excellent, although bureaucratic misadventure kept two members away. The meeting provided the setting for two important transitions. First was the election of Professor Lars H Lindholm as the next President of ISH.

Lars has served the Society with diligence and distinction since joining its Scientific Council in 2000. For the past two years he has been an active member of its Executive Committee, and also edited the highly successful ISH Newsletter. Lars is also widely respected for distinguished leadership of many major international trials of antihypertensive therapy, as well as for careful analysis of controversial issues in antihypertensive therapy. His widely respected editorial commentaries appear frequently in leading international medical journals. In sum, Lars H Lindholm is uniquely well suited to provide creative and effective leadership for our increasingly active society.

Professor Lars H Lindholm will serve as President-Elect before assuming the Presidency at the conclusion of the 21st Scientific Meeting in Fukuoka, Japan, October 15–19, 2006.

The Scientific Council Meeting also marked transfer of administrative responsibility from the very capable hands of Ms. Sue Davenport in Geneva to the Hampton Medical Conference Group in London. Under the direction of Ms. Jacinta Scanell and Elaine Oliver, the transition has been elegantly accomplished. A more detailed description of their exciting plans for the future, including the launch of a new website, are detailed elsewhere in this issue.

The Scientific Council also received encouraging reports on progress for the two upcoming Scientific Meetings in Fukuoka (2006) and Berlin (2008). Professors Ogihara, a current member of the Scientific Council, and Saruta, a past council member, have assembled able and effective Organizing and Program Committees. Professor Trevor Morgan has announced that the Asian-Pacific Society of Hypertension, of which he is President, will hold its 5th congress in conjunction with the Fukuoka meeting. Thus, a remarkable confluence of local, regional, and international support ensures a large turnout for what promises to be an outstanding scientific program in a most appealing venue.

Timely state-of-the-art lectures, breakfast symposia, and late-breaking clinical trials have been planned. In addition, there will be nearly 100 oral as well as poster presentations selected from submitted abstracts. I urge all members to submit their best research work for presentation (abstract deadline April 15, 2006) at Fukuoka, and make travel plans early.

On another note, former ISH President John Chalmers and Dr. Liu Leshang organized an ISH Faculty visit to China in August. Pavel Hamet, Simon Thom, Judith Whitworth, and I participated in lively symposia in Shanghai, Chendu, Wuhan, and Beijing.

The visit provided an opportunity for many Chinese physicians to become familiar with ISH, and for us to establish personal ties with a number of very able young Chinese investigators. The possibility of further visits to this most vibrant country, perhaps to coincide with the Fukuoka meeting, was discussed.

At the Fukuoka meeting of the Scientific Council in 2006, new members of the Scientific Council will be elected. Terms are initially for four years, but generally are extended for an additional second term. I urge members to contact me or other Council Members with suggestions for suitable candidates. Formal nominations must be received by the summer of 2006.

Hampton Medical Conferences (HMC) Ltd The new ISH agent

We recently appointed Hampton Medical Conferences Ltd (HMC) to provide secretariat services for the Society.

Based in Hampton Hill, Middlesex, UK, HMC has considerable experience of association management, having been retained by a number of medical societies to provide a complete administrative service. They specialize in the organization of medical symposia, offering a service to academic societies and associations, individual physicians and the pharmaceutical industry. The company is already familiar with the work of the ISH having been responsible for the Scientific Secretariat for the 16th Scientific Meeting of the International Society of Hypertension in 1996 in Glasgow, UK. For this meeting they handled over 2,300 abstract submissions, 500 referees, 400 speakers and chairmen, 1,200 poster presentations, 3 different awards/travel grants linked to abstract submission and 5 Conference Sub-Committees.

Their clients include UK and international medical societies and associations, pharmaceutical companies and individual physicians with innovative meeting ideas.

HMC was formed in June 1988 and now has 20 permanent staff, together with a regular team of freelance conference staff, who organize events throughout the UK, Europe and worldwide. They offer a complete range of services associated with conference and exhibition management and secretariat services. Their bespoke delegate management systems will be tailored to meet the specific needs of the ISH, including a secure online payment and membership renewal system.

Brief facts about HMC to date:

- Ordered more than **500,000** cups of coffee!
- Processed **54,202** delegates
- Sold **7,079** exhibition stands and sponsorship packages
- Invited **5,596** speakers
- Managed **544** round table meetings
- Organised **368** conferences

The team at HMC have already developed a new website for the ISH and we urge you to log on and visit us at www.ish-world.com. Further developments are planned including a secure membership area where you will be able to read the newsletter in due course.

If you wish to correspond with the new secretariat, please contact them at:

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Directors of Hampton Medical

The Joint Managing Directors, Elaine Oliver and Jacinta Scannell, are both fully elected members of the Association of British Professional Conference Organisers (ABPCO) and agree to abide by the Code of Practice laid down by the Association. Both Elaine and Jacinta will be working closely with the Executive Committee and Council to manage the Society.

Elaine Oliver

Elaine Oliver has 12 years experience of organizing medical conferences both at the British Medical Association and at Hampton Medical Conferences. Events range from intimate workshop-style meetings to international congresses with up to 1500 delegates; her experience includes the organization of associated exhibitions and social events. Elaine was appointed as Joint Managing Director in February 2002 since when she has managed this progressive company.

**Jacinta Scannell**

Jacinta Scannell has worked in administration for over 20 years. Her early career was in industry but since moving to London in 1989, she has worked in conference management. As the senior administrator and conference organizer for a professional academic association for 10 years Jacinta developed a very solid understanding of committee administration. She was also responsible for ensuring that the organization fulfilled its constitutional and statutory requirements under rule. As Joint Managing Director at HMC, she shares responsibility for business development, staffing, and all event management.



For this issue of HT News we invited Professors W. Birkenhäger, J Staessen, and J Chalmers to give their comments on the ASCOT results. We also invited the two first authors of the recent Lancet publications, Professor Neil Poulter and Doctor Björn Dahlöf, to respond which, however, they declined to do in order to “keep their powder dry pending the Lancet correspondence columns”.

Lars H Lindholm
Editor, ISH News

ASCOT supports superiority of newer over older antihypertensive drugs

W. H. Birkenhäger
Rotterdam, The Netherlands

Jan A. Staessen
Leuven, Belgium

This is another important milestone in the series of prospective randomized comparative hypertension trials.

As in previous trials of this class (VALUE etc.) study subjects were selected on the basis of hypertension plus one or several additional CV risk factors. This is quite appropriate from an ethical point of view; moreover, this choice facilitates the evaluation of the outcome in a relatively short period, given the unwritten but generally recognized law that the greater the initial risk, the better the chance of attaining significant differences between randomized group outcomes. This obviously reduces the time scale of a trial. On the other hand, these tactics imply that the results (differences in outcome) need not necessarily be applicable to uncomplicated “middle of the road” hypertensives as seen in daily practice.

It is argued that the “ancient” combination of a beta-blocker and a thiazide diuretic, despite their complementary beneficial effects on blood pressure as such, shares common disadvantages of potentially harming the metabolic status of patients so treated. Such unwanted effects as the new onset of diabetes and dyslipidaemia (in the meantime recognized as components of the metabolic syndrome in substantial numbers of hypertensives) may well neutralize any favourable effect on blood pressure *per se*.

By contrast, the newer antihypertensive agents, such as the dihydropyridine class of calcium channel blockers, ACE inhibitors, and AT1-blockers are apparently devoid of such potentially ominous effects. The pharmaceutical industry, for obvious reasons, has shown to be keen on carrying the message one step further, by claiming that the new antihypertensive agents (with accents on their trade marks!) may even harbour the potential of improving cardiovascular status over and above their ability to achieve blood pressure control! In our perception this venture is one bridge too far, in general terms of explaining such favourable outcomes.

Back in 2001 one of us (J.A.S. et al) introduced another interpretation through a “meta-regression” analysis of blood pressure differences and demonstrated that differences in cardiovascular outcome between different regimens could readily be explained on the basis of relatively tiny gradients in systolic blood pressure.

This evaluation was updated in 2003. It appeared in the meantime that in such huge trials, as the present one, it is quite difficult, if not impossible, to achieve complete equivalence of average systolic blood pressure between groups assigned to different treatment regimes. The differences in outcome correlated well with such ostensibly tiny in-trial differences in systolic blood pressure. This also applies to the ASCOT trial.

The conclusion seems justified that the newer drugs simply turn out to be better antihypertensives, although it still remains to be established which of the latter would be preferable as first-line drug.

Furthermore, the findings do not exclude the possibility that some antihypertensive agents may exert specifically beneficial actions on such sensitive end organs as the kidney or the brain, irrespective of their effects on blood pressure. The kidneys seem to profit most from drugs inhibiting the renin-angiotensin system, although according to some studies dihydropyridine calcium channel blockers may achieve comparable effects.

The main concern of our profession should extend to our single irreplaceable organ, the brain. Strokes as such to an appreciable extent have shown to be preventable through timely antihypertensive treatment. But the dementias (both Alzheimer's disease and vascular dementia) loom ahead as a major (pandemic) scourge in the increasingly elderly population. Time and again it has been demonstrated that hypertension is a main (and potentially remediable) factor in the pathogenesis of both dementia subtypes.

Why is it, then, that hypertension trialists apparently tended to turn a blind eye to this most challenging of end points and that a potential wealth of preventive information has gotten lost down the drain in the majority of valuable comparative trials? One can only speculate that it must have been due to reluctance to tread unknown paths, even though the placebo-controlled Syst-Eur trial, followed by the SCOPE and PROGRESS trials, have demonstrated the feasibility of incorporating at least such simple screening test as the M.M.S.E. (Mini-Mental State Examination), which upon meta-analysis indicated an exclusive benefit of 50–55% prevention or postponement of dementia based on a dihydropyridine calcium antagonist (nitrendipine).

Despite the squandering of such essential information in the above comparative mega-trials, one still may be facing further opportunities for compensating for those lost opportunities. Given the better performance of the new drugs combination in ASCOT-BPLA, there will still be a need for establishing a preferential first single treatment agent (dihydropyridine CCB, ACE-inhibitor, AT1-blocker ...) and a common additional drug if necessary. That would provide a golden opportunity for incorporating a psychometric follow-up assessment on top of the usual range of somatic evaluations and hence paving the way towards optimal prevention of mental deprivation in hypertensives.

ASCOT – An Anglo-Scandinavian triumph!

John Chalmers

Sydney, Australia

What a study! Few deliver half of what their initiators dare to hope for. This one has turned up trumps in almost every respect, and ahead of time! – both arms of the 2x2 factorial stopped early due to impressively positive results.

The first to be stopped, ASCOT-LLA (The Lipid Lowering Arm), was halted after 3.3 years of a planned 5-year follow-up (1). Among 10,305 hypertensive patients with a non-fasting total cholesterol of 6.5 mmol/l or less, only 100 patients on atorvastatin 10 mg had a primary event (non-fatal MI and fatal CHD), compared to 154 on placebo (a hazard ratio of 0.64). Kaplan-Meier curves revealed separation and a trend to benefit from the first few months, and most secondary endpoints (total stroke, total coronary events, total coronary events and procedures) were reduced by between 20 and 30% in the group receiving atorvastatin (1).

Now ASCOT-BPLA, the second, blood pressure lowering arm, has been stopped before reaching its target of 1150 primary events, because mortality and a majority of other secondary endpoints were clearly more frequent on conventional combination therapy (atenolol and bendroflumethiazide based therapy) than on combination therapy with newer drugs (amlodipine and perindopril based therapy) (2).

Among 19,257 patients with moderately severe hypertension (untreated >160/90 mmHg or treated >140/90 mmHg) and at least three other cardiovascular risk factors, all-cause mortality and cardiovascular mortality were reduced by 11% ($p=0.025$) and 24% ($P=0.001$) respectively in the group assigned to the amlodipine/perindopril combination strategy compared to those on the atenolol/bendroflumethiazide combination strategy. In addition secondary endpoints such as total stroke (by 23%), total coronary events (by 13%), total coronary events and procedures (by 16%) were all significantly reduced in those on the newer agents. The risk of new onset diabetes was also reduced by 30% by the amlodipine/perindopril strategy. Interestingly, there was no significant reduction in heart failure in those on the newer agents, potentially revealing the negative effects of calcium antagonists in this respect, reported in other studies (3, 4).

ASCOT-BPLA is the first trial that seeks formally to compare 2 “combinations”, one with 2 “newer agents” (amlodipine and perindopril) and the other with 2 “older drugs” (atenolol and bendroflumethiazide) but even this is really a comparison between 2 treatment algorithms, which the authors term “treatment strategies” since overall only around half were actually taking each of the two nominated combinations throughout the trial (2).

The striking benefit that the “newer agent” strategy combining amlodipine and perindopril conferred on most cardiovascular endpoints in ASCOT-BPLA, is difficult to reconcile with the singular lack of advantage detected when amlodipine and lisinopril were each compared head to head with chlorthalidone in ALLHAT (3).

It is also difficult to reconcile the results of ASCOT-BPLA with the lack of difference in the risk of stroke and coronary disease between ACE inhibitors, or Calcium Antagonists on the one hand and “conventional” therapy on the other, reported by the Blood Pressure Lowering Treatment Trialists’ Collaboration (4).

It is not at all clear whether the cardiovascular benefits of the amlodipine/perindopril strategy reflect specific benefits of these two particular agents, class benefits associated with calcium antagonists and/or ACE inhibitors, specific negative effects of either atenolol or bendroflumethiazide, or negative class effects associated with beta blockers and/or diuretics. While many readers will tend to attribute the results to the beneficial effects of calcium antagonists and ACE inhibitors, a few may be tempted to blame atenolol, which has been found wanting elsewhere (5, 6). Thus the differences compared to ALLHAT could be attributed by a mischievous commentator to the negative effects in ASCOT-BPLA of atenolol, or even to the superior effects in ALLHAT of chlorthalidone (2, 3).

Commentators and readers will all note that the blood pressures were lower by 2.7/1.9 mmHg in the amlodipine/perindopril group, a difference reminiscent of the HOPE study (7) where an ACE inhibitor also achieved significant benefits with only a small difference in blood pressure. The relative contribution to the benefits seen in ASCOT-BPLA of this blood pressure difference, particularly the 2.7 mm Hg difference in systolic blood pressure, and of other drug-related characteristics is already a bone of contention (8,9). This debate, fuelled by the back-to-back publication of the companion paper (8), is unfortunate, especially as the analyses presented are polluted by non-randomized data, and as the authors themselves admit, their multivariate adjustment procedures are incomplete and likely to underestimate the true effects of the variables considered, such as the blood pressure (8). The argument detracts from the main conclusions to be drawn from ASCOT-BPLA, that the newer agents, amlodipine and perindopril are remarkably effective blood pressure lowering drugs, remarkably effectively in reducing cardiovascular mortality and morbidity and very effective in reducing the onset of newly diagnosed diabetes (2). The argument also muddies the main message, that the key to reducing the morbidity and mortality with these two agents is effective blood pressure reduction and the more the merrier!

The results and the authors' interpretation of ASCOT-BPLA plainly balance out the results and the authors' interpretation of ALLHAT(3), two studies of similar weight, with around 10,000 participants in the various randomized treatment groups (2, 3). In one, the authors of ALLHAT argue that conventional treatment (the diuretic chlorthalidone) is superior and should constitute the preferred initial treatment, while in the other, the authors of ASCOT-BPLA argue that newer agents (in this case the calcium antagonist amlodipine and the ACE inhibitor perindopril) are superior and that conventional treatment with a beta blocker and a diuretic should not be preferred for routine use. Indeed, the ASCOT authors would restrict the use of the beta blocker/diuretic combination to "specific circumstances". My own view, given the new evidence from ASCOT-BPLA (2), would sit between the two. I would now neither prefer nor avoid conventional therapy with diuretics and beta blockers, and in this respect, I would agree with the recommendations of the 2003 European Guidelines and indeed with those of the 1999 WHO-ISH Guidelines for the treatment of hypertension (10, 11). Both these guidelines recommend that the doctor should choose from among the 5 classes of front-line drugs, and tailor this choice according to the clinical situation in the individual patient (10, 11). They also stress the importance of a combination therapy. This advice seems appropriate in the light of all the evidence that is currently available.

The results of ASCOT certainly vindicate the use of newer drugs and in particular they re-enforce the need for combination therapy using a multiplicity of drugs in coherent therapeutic strategies.

Even in ASCOT-BPLA, the proportions of patients meeting international recommendations for blood pressure control were as low as one third for diabetic patients and less than two thirds for non-diabetic subjects (2), highlighting the difficulties faced by clinicians in their usual practice situations.

While cost factors must most certainly be taken into account in all nations, whether high, middle or low income, the overwhelming public health message must continue to be to “lower blood pressure more stringently to meet target blood pressures, using rational combinations of all the drugs available in your health system, in order to reduce the risk of fatal and non-fatal heart attack, stroke and heart failure”. It is also tempting to add a rider that in subjects with diabetes, or at risk of developing diabetes such as those who are overweight, an inhibitor of the renin-angiotensin system should be included.

Most good clinical trials throw up many new questions as well as answers, and ASCOT is no exception. But ASCOT is quite exceptional in answering most of the main questions that it was designed to address, in both ASCOT-LLA (1) and ASCOT-BPLA (2). Congratulations and plaudits to all involved.

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Report from the Editor of the Journal of Hypertension
A Zanchetti
Milan, Italy

The Journal of Hypertension: Citations and Impact Factor

The members of the International Society of Hypertension are naturally quite interested in the official journal of their Society, and have certainly been excited to learn a few months ago that the impact factor of the Journal of Hypertension has risen to 4.871, with a considerable further increase over the continuing trend to increased attention in previous years.

Obviously, the impact factor has limitations: although it gives a satisfactory assessment of the impact the journal is having on scientific information, it does not provide editors and authors with a lead to which articles are receiving the greatest interest from their fellow scientists. Knowing the number of citations for individual papers and types of paper can be of undoubted interest, however. Therefore, I have tried to provide ISH members with some information about the citations through which the flattering impact factor of the Journal of Hypertension has been achieved.

With the valuable help of Mrs Mara Bernardinello, librarian of the Istituto Auxologico Italiano, Milan, I am now able to present some summary information on the Journal of Hypertension articles published in 2002 and 2003 that have been more frequently cited in the period until 31 Dec 2004.

Because of the time delay between publication of an article and its citation by other published articles, we have searched the ISI Web of Science for citations of papers appearing in the Journal of Hypertension during the year 2002 (volume 20) and, separately, during the year 2003 (volume 21).

Among papers published in 2002, 72 had received at least 10 citations in peer-reviewed journals by December 2004. Of these, 13 were reviews, meta-analyses, guidelines, editorial commentaries, but as many as 59 were original papers. Fifteen articles (6 reviews or editorials) had received 20 or more citations. These are listed below.

1. Lindholm LH et al. Risk of new-onset diabetes in the LIFE study. 2002; 20: 1877.
2. Simon A et al. Intima-media thickness: a new tool for diagnosis and treatment of cardiovascular risk. 2002; 20: 159 (Review)
3. Mark AL et al. Selective leptin resistance. 2002; 20: 1245 (Review)
4. Zanchetti A, Ruilope LM. Antihypertensive treatment in patients with type 2 diabetes mellitus. 2002; 20: 2099 (Review)
5. Gorzelniak K et al. Hormonal regulation of the human adipose-tissue renin-angiotensin system: relation to obesity and hypertension. 2002; 20: 965.
6. Fagard RH et al. Survey on the treatment of hypertension and implementation of WHO/ISH risk stratification in primary care in Belgium. 2002; 20: 1297.
7. Gasowski J et al. Pulsatile blood pressure component as predictor of mortality in hypertension. 2002; 20: 145 (Meta-analysis)
8. Ohkubo T et al. Prognostic significance of the nocturnal decline in blood pressure: the Ohasama study. 2002; 20: 2183.

9. Cuspidi C et al. The role of echocardiography and carotid ultrasonography in stratifying risk in patients with essential hypertension: the APROS study. 2002; 20: 1307.
10. Redon J, Williams B. Microalbuminuria in essential hypertension: redefining the threshold. 2002; 20: 353 (Editorial commentary)
11. Schiffrin E et al. Effect of crossing over from a beta-blocker to an angiotensin-receptor antagonist on resistance artery structure and on endothelial function. 2002; 20: 71.
12. Wachtell K et al. Microalbuminuria in hypertensive patients with electrocardiographic LHV: the LIFE study. 2002; 20: 405.
13. Dahlof B et al. Effects of losartan and atenolol on left ventricular mass and neurohormonal profile in hypertensives with LVH. 2002; 20: 1855.
14. Ferrari P et al. Additive antiproteinuric effect of combined ACE inhibition and angiotensin II receptor blockade. 2002; 20: 125.
15. Mancia G, Grassi G. Systolic and diastolic blood pressure control in antihypertensive drug trials. 2002; 20: 1461 (Editorial).

Because of the shorter time elapsed since publication, a lower number of articles published in volume 21 (2003) have received a conspicuous number of citations. 18 articles (of which 8 guidelines and reviews) have received at least 10 citations, with the top six papers having received at least 20 citations (and the ESH/ESC guidelines more than 250).

1. Guideline committee. 2003 ESH-ESC guidelines for the management of hypertension. 2003; 21: 1011 (Guidelines)
2. Writing group. 2003 WHO-ISH statement on hypertension management. 2003; 21: 1977 (Guidelines)
3. Lithell H et al. The SCOPE trial. Principal results. 2003; 21: 875.
4. O'Brien E et al. ESH recommendations for conventional ambulatory and home blood pressure measurement. 2003; 21: 821 (Guidelines)
5. Staessen J et al. Cardiovascular prevention and blood pressure reduction: a quantitative overview updated until 1 March 2003. 2003; 21: 1055 (Meta-analysis)
6. Asia Pacific Cohort Studies Collaboration. Blood pressure and cardiovascular disease in the Asia-Pacific region. 2003; 21: 707 (Meta-analysis)
7. Lindholm LH et al. Metabolic outcome in newly detected hypertensives. The ALPINE study. 2003; 21: 1563.
8. Davies JI et al. Peripheral blood pressure measurement is as good as applanation tonometry at predicting ascending aortic blood pressure. 2003; 21: 571.
9. Hope DA et al. Use of arterial transfer function. 2003; 21: 1299.
10. ISH Writing Group. 2003 ISH statement on blood pressure lowering and stroke prevention. 2003; 21: 651 (Guidelines)
11. Lin Y et al. Central cardiovascular action of urotensin II in conscious rats. 2003; 21: 159.
12. Davies BJ et al. Disparate effects of ARBs and CCBs on albuminuria in experimental diabetes. 2003; 21: 209.
13. Aronson D. Cross-linking of glycated collagen in arterial and myocardial stiffening of aging and diabetes. 2003; 21: 3 (Review).
14. ISH Writing Group. 2003 ISH statement on the management of blood pressure in acute stroke. 2003; 21: 665 (Guidelines).
15. Vonend O et al. Moxonidine in renal failure. 2003; 21: 1709.
16. Grassi G et al. The CROSS study. 2003; 21: 1761.

17. Brand E et al. Blood pressure and metabolic phenotypes in relation to the G 3 C825T polymorphism. 2003; 21: 729.
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On the whole, although guidelines and reviews do more easily receive citations, a conspicuous number of citations also concern many original papers, clinical and experimental. Giving consideration to the preferences of the readers (web-users, see information on Opus no. 6) and to the slightly different ones of investigators (those citing papers relevant to their work), may help the readers in finding the most interesting information in our Journal, prospective authors in deciding which of their papers is most suitable for our Journal, and the editors in trying to make the Journal of Hypertension even more stimulating for the readers and widely cited in the medical literature.

Israeli Society of Hypertension – 2004-2005

E. Grossman

Tel-Hashomer, Israel

High blood pressure is a major health concern in Israel as it is in the other countries of the European Society of Hypertension. The Israeli Society of Hypertension includes more than 400 physicians who work in various fields of medicine such as general practice, internal medicine, cardiology, nephrology, endocrinology, epidemiology, research etc. The executive board includes the president, secretary, treasurer, ex-president and two members. Elections take place every two years. The Israeli Society of Hypertension carried out actions to increase the awareness and to implement the recent guidelines to diagnose and treat hypertension among the Israeli population. The Israeli Society of Hypertension works to increase awareness among the population and put emphasis on clinical education of family physician and interaction with other medical societies such as Cardiology, Diabetes and Nephrology. The Israeli Society of Hypertension believes that since most hypertension patients have additional co-morbid conditions, an integrative approach and dialogue with other professional associations is mandatory.

Epidemiology

Physicians who work for the main HMOs in Israel use an electronic medical record, which sends data sets to the HMO central computer. It has therefore been possible to build a hypertension registry. This registry is automatically updated every month and is displayed on-line. Analysis of the data of one and a half million subjects who are older than 18 years showed that the prevalence of *diagnosed* hypertension in Israel is about 18%. However, about 40% of the subjects don't have blood pressure measurements during the last 2 years in their records. Among 189,737 patients in Maccabi Healthcare Services who had a diagnosis of hypertension 51% had satisfactory blood pressure control with recorded blood pressure levels below 140/90 mm Hg.

In a survey conducted by the Israeli Society of Hypertension during the last year the patterns of drug treatment among primary care physicians were evaluated. We found that almost 70% of the hypertensive patients have, in addition to hypertension, 3 cardiovascular risk factors or diabetes mellitus. These findings imply that most hypertensive patients are high-risk patients and should be treated aggressively to control other cardiovascular risk factors. In this survey we found that beta blockers and ACE inhibitors were the leading antihypertensive agents and were given to 26.1% and 25.4% of the patients respectively. Calcium antagonists and diuretics were given to 21.2% and 18.3% of the patients respectively. Angiotensin receptor blockers (ARBs) were given to only 3.4% of the patients. The low use of ARBs may reflect the limit imposed by the government on the use of expensive antihypertensive agents. Recently, the Israeli Society of Hypertension did a survey to calculate the 10-year risk of developing stroke in 1300 elderly hypertensive patients. Preliminary analysis shows that the calculated 10-year risk of stroke in elderly hypertensive patients is higher than the calculated risk of myocardial infarction, and that most physicians underestimate the risk of stroke in elderly hypertensive patients. The Israeli Society of Hypertension in collaboration with the Ministry of Health is running now a study in 1500 elderly subjects around the country to assess the rate of hypertension and co-morbidities and the awareness and rate of blood pressure control in this population.

Education

The Israeli Society of Hypertension published guidelines for the diagnosis and treatment of hypertension early 2004. This guidelines reflect the principles of the European Society of Hypertension (ESH) guidelines and modified them to the Israeli population and health system. Integrative guidelines for a global risk reduction in the patient with multiple risk factors have been completed and are about to be published.

A clinical education programme was initiated last year. A monthly meeting of family physicians and hypertension specialists is taking place, during which an update seminar and clinical case management are reviewed with active participation of the audience and commentary by the specialists.

The Third Hypertension School took place this year. Physicians after their specialization, primarily in internal medicine, cardiology, nephrology, endocrinology and family medicine, who wish to broaden their knowledge in the field of hypertension are the audience of this programme. Both theoretical and practical aspects of hypertension are discussed.

The Israeli Society of Hypertension sponsored young investigators to participate in international meetings. In addition the Israeli Society of Hypertension encourages young physicians to participate in the European educational programmes, such as the summer hypertension school and the advanced hypertension school. Last year two Israeli members participated in the summer hypertension school and one physician participated in the advanced hypertension school.

The Israeli Society of Hypertension established a 2-year programme of fellowship in hypertension for physicians who are specialist in internal medicine or family medicine. The program includes clinical work in a recognized hypertension clinic and clinical and basic research in hypertension. We now have two fellows who have started this programme.

The Israeli Society of Hypertension has a website, www.ISH.org.il, where all the activities are listed. The website has an update section where the recent literature is reviewed every month, and a Q&A section where physicians and the general population can ask questions and give answers. In addition, the Israeli Society of Hypertension distributes a monthly electronic paper to all the members.

Meetings

The Israeli Society of Hypertension has organized two annual meetings. Both state-of-the-art lectures as well as clinical and basic research are presented.

Research

The Israeli Society of Hypertension supports basic and clinical research through research grants.

HT News Opus 8

G. Mancia

Monza, Italy

The Fifteenth Meeting of the European Society of Hypertension has been held in Milan from June 17–21, 2005. The meeting was an outstanding success because of the large attendance and the high quality of the highly diversified scientific programme. About 6,500 clinicians and investigators from all European and many non-European countries participated in the scientific sessions which accommodated 186 oral presentations, 10 lectures, 2 debates and 1161 posters. In addition many sessions were pre-structured (Topical Workshops) to address issues of current interest dealt with by worldwide experts. Specific treatment options were addressed in the context of 14 drug-company-sponsored symposia, while other symposia on more basic topics were organized by investigators either in Milan or at other Italian venues, as well as outside Italy (Cracow and Mykonos). About 300 oral or poster presenters from various countries received travel or accommodations grants to help them to participate in the meeting and accumulate experience that may help their future research. Thus the meeting continued the traditional success of yearly ESH scientific events. This is a good omen for the future meeting which will be held in Madrid in June 2006.



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INTERNATIONAL SOCIETY OF HYPERTENSION

A member of the Scientific Advisory Board
of the **World Heart Federation**

HOW TO BECOME A MEMBER OF THE

**INTERNATIONAL SOCIETY
OF HYPERTENSION (ISH)**

Applications should be made in writing to the Secretary of the Society,

Professor Anna F Dominiczak, at the address below, accompanied by a written statement from two members of the Society as to the qualifications of the applicant plus a list of the five best and the five most recent publications related to hypertension or allied fields as well as a short curriculum vitae (CV).

Professor A F Dominiczak
ISH Secretariat
Hampton Medical Conferences Ltd.
113-119 High Street, Hampton Hill
Middlesex, TW12 1NJ, U.K.

Tel: +44 (0) 20 8979 8300
Fax: +44 (0) 20 8979 6700
Email: secretariat@ish-world.com

MEMBERSHIP OF THE INTERNATIONAL SOCIETY OF HYPERTENSION (ISH)

APPLICATION FORM

TITLE

SURNAME

FORENAMES:

INSTITUTION:

ADDRESS:

Telephone No: Fax No:

Email:

NAMES AND ADDRESSES OF TWO ISH MEMBERS WHO SUPPORT THE APPLICATION

NAME:

ADDRESS:

NAME:

ADDRESS:

APPLICATIONS SHOULD BE MADE IN WRITING TO THE SECRETARY OF THE SOCIETY, PROFESSOR ANNA F DOMINICZAK ACCOMPANIED BY A WRITTEN STATEMENT FROM TWO ISH MEMBERS.

A LIST OF THE FIVE BEST AND THE FIVE MOST RECENT PUBLICATIONS RELATED TO HYPERTENSION OR ALLIED FIELDS SHOULD BE ENCLOSED AS WELL AS A SHORT CURRICULUM VITAE (CV).

Professor A F Dominiczak
ISH Secretariat
Hampton Medical Conferences Ltd.
113-119 High Street, Hampton Hill
Middlesex, TW12 1NJ
U.K.

**THE ANNUAL ISH MEMBERSHIP FEE AND SUBSCRIPTION TO
THE JOURNAL OF HYPERTENSION IS CURRENTLY USD 136.50**

Payment should **not** be made until membership is approved. Applications for membership will be assessed by the Membership Committee and ratified at the next ISH General Business Meeting.